IDAHO DEPARTMENT OF
HEALTH & WELFARE

JAMES E. RISCH – Governor
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BUREAU OF FACILITY STANDARDS
3232 Elder Street
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August 29, 2006

Clinical Inspection
Original

Ann Oglevie
Weiser Memorial Hospital
645 East 5th Street
Weiser, ID 83672

Dear Ms. Oglevie:

This is to advise you of the findings of the Medicare survey at Weiser Memorial Hospital which was concluded on August 22, 2006.

Enclosed is a Statement of Deficiencies/Plan of Correction, Form CMS-2567, listing Medicare deficiencies and a similar form listing State licensure deficiencies. In the spaces provided on the right side of each sheet, please provide a Plan of Correction. It is important that your Plan of Correction address each deficiency in the following manner:

1. Answer the deficiency statement, specifically indicating how the problem will be, or has been, corrected. Do not address the specific examples. Your plan must describe how you will ensure correction for all individuals potentially impacted by the deficient practice.

2. Identify the person or discipline responsible for monitoring the changes in the system to ensure compliance is achieved and maintained. This is to include how the monitoring will be done and at what frequency the person or discipline will do the monitoring.

3. Identify the date each deficiency has been, or will be, corrected.

4. Sign and date the form(s) in the space provided at the bottom of the first page.

After you have completed your Plan of Correction, return the original to this office by **September 12, 2006**, and keep a copy for your records.

Thank you for the courtesies extended to us during our visit. If you have any questions, please call or write this office at (208)334-6626.

Sincerely,

PENNY SALOW, R.N.
Health Facility Surveyor
Non-Long Term Care

SYLVIA CRESWELL
Supervisor
Non-Long Term Care

PS/mlw

Enclosures

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	131307	A. BUILDING _____ B. WING _____	08/22/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEISER MEMORIAL HOSPITAL	645 EAST 5TH WEISER, ID 83672

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
C 000	INITIAL COMMENTS The following deficiencies were cited during the Medicare recertification survey of your Critical Access Hospital. The surveyors conducting the Medicare recertification survey were: Penny Salow, R.N., H.F.S., Team Leader Gary Guiles, R.N., H.F.S. Deb Dore', R.N., H.F.S. Abbreviations include: CAH = Critical Access Hospital CNO = Chief Nursing Officer RN = Registered Nurse OR = Operating Room RD = Registered Dietitian QA = Quality Assurance	C 000		
C 279	485.635(a)(3)(vii) POLICIES - NUTRITION The policies include, if the CAH furnishes inpatient services, procedures that ensure that the nutritional needs of inpatients are met in accordance with recognized dietary practices and the orders of the practitioner responsible for the care of the patients, and that the requirement of §485.25(i) is met with respect to inpatients receiving post-hospital SNF care. This STANDARD is not met as evidenced by: Based on staff interview and review of clinical records, it was determined the CAH failed to ensure nutritional needs were met for 1 of 1 patients (#19), whose record described nutritional concerns. The CAH failed to ensure a system was in place to identify patients with significant nutritional needs and refer those patients to the	C 279	G279 Nutritional Policies Instructed the Dietary Supervisor and Registered Dietician on 8-23-06 concerning the Standard of Care. Revised policy & procedure (P&P) D-2 Dietary Documentation of Patient Consultation Registered Dietician contract reviewed and revised. Nursing Personnel in-serviced on survey findings as of 9-5-06. Dietary Supervisor is responsible to ensure that patient's nutritional assessment are being done. This will be a quality improvement indicator and will be tracked for 3 months.	9/1/06

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Interim CEO — 9/11/2006

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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C 279	Continued From page 1 RD for evaluation. This created the potential that patients would have unmet nutritional needs. The findings include: Patient #19 was admitted to the CAH on 6/29/06 with newly diagnosed Type II diabetes mellitus with hyperosmolar nonketotic acidosis. The patient was initially started on Insulin in the form of a sliding scale and at discharge was taking Lantus Insulin 80 units daily. She was discharged on 7/3/06 and referred to a diabetic clinic for diabetic teaching. No documentation was found to indicate the patient received a dietary consult or dietary assessment during her hospitalization. The Dietary Supervisor was interviewed on 8/22/06 at 2:45 PM. She stated there was not a specific policy/procedure for initiating a referral to the RD. She stated if nursing put in a request, it would be done. During the same interview the CNO stated there were no specific guidelines for when the dietician would be consulted. The RD/dietary consultant's contract stated the RD was to complete a nutritional assessment in conjunction with the food service supervisor. In addition, the contract stated the dietician was to visit the facility every other month and submit a report on all phases of dietary services, policies and procedures, assessments of food service and all special diets ordered .... According to the Dietary Supervisor's interview on 8/22/06 at 2:45 PM, this had not occurred.	C 279	G279 Nutritional Policies Instructed the Dietary Supervisor and Registered Dietician on 8-23-06 concerning the Standard of Care. Revised policy & procedure (P&P) D-2 Dietary Documentation of Patient Consultation. Registered Dietician contract reviewed and revised. Nursing Personnel inserviced on survey findings as of 9-5-06. Dietary Supervisor is responsible to ensure that patient's nutritional assessments are being done. This will be a quality improvement indicator and will be tracked for 3 months.	9/10/06

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C 321	485.639(a) SURGICAL PRIVILEGING The CAH designates the practitioners who are allowed to perform surgery for CAH patients, in accordance with its approved policies and procedures, and with State scope of practice laws. Surgery is performed only by a doctor of medicine or osteopathy, including an osteopathic practitioner recognized under section 1101(a)(7) of the Act; a doctor of dental surgery or dental medicine; or a doctor of podiatric medicine. This STANDARD is not met as evidenced by: Based on staff interview and review of practitioner credentials files, it was determined the hospital failed to designate the practitioners who were allowed to perform surgical procedures in the CAH. The CAH failed to ensure a current roster, listing 12 of 12 practitioners' (Practitioners A - L) specific approved privileges, was maintained in the surgical suite. In addition, the CAH failed to ensure 1 of 12 practitioners (Practitioner A) had been granted privileges to perform procedures that had been performed. The findings include: 1. The surgical suite was toured on 8/21/06 at 1:15 PM, and the OR Director was interviewed. She stated there currently were 12 practitioners who performed surgical procedures in the CAH. She stated a list of those practitioners' and their current privileges was not available in the surgery suite. 2. Credentials files were reviewed on 8/22/06 at 9:30 AM. The privilege list for Practitioner A did not include privileges for total knee replacement. The operating room log documented Practitioner A had performed this operation at the hospital. During the review, the Director of Health Information confirmed the lack of surgical	C 321	G321 Surgical Privileging. An updated list of physician roster and privileges is now available in the OR. HIM department in-serviced the Medical Staff on 9-6-06 regarding the list of privileges that each of them have documented. The HIM manager is responsible to ensure current and accurate physician rosters & privileges are available and kept updated. This is a QI indicator and it will be tracked monthly. This will be monitored by the HIM Manager.	9/10/06

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C 321	Continued From page 3 privileges for Practitioner A.	C 321		
C 336	485.641(b) QA - QUALITY OF PATIENT CARE The CAH has an effective quality assurance program to evaluate the quality and appropriateness of the diagnosis and treatment furnished in the CAH and of the treatment outcomes. This STANDARD is not met as evidenced by: Based on staff interview and review of QA program documentation, it was determined the CAH failed to ensure an effective QA program was maintained. The CAH failed to ensure quality indicator data was compiled and evaluated to determine if problems existed and required corrective actions. This created the potential for unidentified problems related to care and services. The findings include: 1. The CAH's QA program was reviewed on 8/22/06. The CAH's QA plan was requested. The QA Coordinator found the plan and other QA documents in a box in the basement. She stated the documents had been in a manual maintained by a previous QA Coordinator. That individual had not worked at the CAH for approximately one year. The "QUALITY IMPROVEMENT PROGRAM" policy was last reviewed and approved on 6/14/05. The procedure described how all CAH services would be evaluated. QA monitoring data was requested from the QA Coordinator. She provided stacks of documents, most of which were not stapled, clipped or	C 336	C336 Quality of Patient Care. QI coordinator and Chief Nursing Officer (CNO) met on 8-23-06 to discuss the organization of the program. This program will be revitalized and made operational This will be monitored by the CNO and the Administrator. 9/14/06	

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C 336	Continued From page 4 otherwise contained. The documents included a list of quality indicators for all hospital departments, as well as, various monitoring data from recent months. Quarterly QA committee meeting minutes were included in the documentation and findings were discussed. Although monitoring data was being collected from all CAH departments, the documentation was not organized in a manner that would enable the Coordinator to evaluate the results. Due to the lack of organized data collection, it was not possible to accurately determine if thresholds were met. It was not possible to accurately identify problems or implement corrective action plans. 2. The QA Coordinator, interviewed on 8/22/06 at 2 PM, stated she had only recently been assigned the QA Coordinator position. She stated she was the third individual assigned to QA in the past year. She stated she had been working with department managers to assist them in entering indicator data in a spread sheet format, but she had not yet had time to set up an organized collection and review system. She stated she was provided approximately four hours per week for QA Coordination activities. She was also the CAH's infection control officer and education coordinator.	C 336	G336 Quality of Patient Care QI coordinator and Chief Nursing Officer (CNO) met on 9-23-06 to discuss the organization of the program. This program will be revitalized and made operational This will be monitored by the CNO and the Administrator. 9/10/2006	

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C 361	485.645(d)(1) RESIDENTS RIGHTS (483.10(b)(3)) The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility. A facility must protect and promote the rights of each resident, including the right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the CAH failed to ensure 2 of 2 Swing-bed patients (#26 and 27) were notified of all of their rights. The CAH failed to ensure the document notifying Swing-bed patients of their rights was complete. The findings include: 1. Swing-bed patient records were reviewed on 8/22/06 and the following issues were identified: * Patient #26 was admitted to Swing-bed status on 2/17/06. The document informing the patient of his rights was signed on the day of admission. The document did not include the right to be informed of the charges for services not covered by Medicare, Medicaid or the per diem rate; the right to participate in care planning; and the right to access and visitation. * Patient #27 was admitted to Swing-bed status on 6/17/06. The document informing the patient of her rights was signed on the day of admission. The document did not include the right to be informed of the charges for services not covered by Medicare, Medicaid or the per diem rate; the	C 361	G361 SWB- Resident/ Patient Rights. The patient rights (F#SWB-003) have been updated to include costs related to service, involvement in the development of his/her care plans and to have access and visitation rights. Nursing Staff were in-serviced on 9-5-06. This will be monitored by the CNO. 9/10/06	

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C 361	Continued From page 6 right to participate in care planning; and the right to access and visitation. 2. The Swing-bed Patients' Rights document was reviewed with the CNO on 8/22/06 at 11:15 AM. She confirmed the document was incomplete.	C 361		
C 385	485.645(d)(4) PATIENT ACTIVITIES (483.15(f)) A facility must care for its residents in a manner and in an environment that promotes maintenance or enhancement of each resident's quality of life. The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. The activities program must be directed by a qualified professional who is a qualified therapeutic recreation specialist or an activities professional who-- o Is licensed or registered, if applicable, by the State in which practicing; and o Is eligible for certification as a therapeutic recreation specialist or as an activities professional by a recognized accrediting body on or after October 1, 1990; or o Has 2 years of experience in a social or recreational program within the last 5 years, 1 of which was full-time in a patient activities program in a health care setting; or o Is a qualified occupational therapist or occupational therapy assistant; or o Has completed a training course approved by the State. This STANDARD is not met as evidenced by:	C 385	G385 SWB- Patient Activities. It is the responsibility of the floor nurse/ designee to make sure that SWB patients have an activity assessment done and documented. Nursing Personnel in-serviced on 8-24-06 and 9-5-06 regarding SWB and survey deficiencies. It will be monitored by the CNO and utilized as a monthly QI indictor. 9/10/06	

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C 385	Continued From page 7 Based on record review and staff interview, it was determined the CAH failed to ensure 2 of 2 Swing-bed patients (#26 and 27) were assessed for activities interests. This created the potential that Swing-bed patients would not be provided with meaningful activities. The findings include: 1. Swing-bed patient records were reviewed on 8/22/06 and the following issues were identified: * Patient #26, an 87 year old male, was admitted to Swing-bed status on 2/17/06 and discharged on 3/3/06. His diagnoses included weakness and debility due to congestive heart failure, chronic renal insufficiency, coronary artery disease and atrial fibrillation. The patient's record did not contain an assessment of his activities interests. In addition, the form titled "ACTIVITIES/BEDSIDE PROGRAMMING" did not contain any documentation to show what, if any, activities had been provided to the patient during his stay. * Patient #27, a 75 year old female, was admitted to Swing-bed status on 6/17/06 and discharged on 6/19/06. Her diagnoses included pneumonia, urinary tract infection and multiple sclerosis. The patient's record contained documentation on 6/17/06, on the "ACTIVITIES/BEDSIDE PROGRAMMING" form, that the patient watched television and visited with family, however, the record did not contain an assessment of her activities interests. 2. The patients' records were reviewed with the CNO on 8/22/06 at 11:15 AM. She confirmed the lack of assessments for activities interests.	C 385	C385 SWB- Patient Activities. (Continued) It is the responsibility of the floor nurse/designee to make sure that SWB patients have an activity assessment done and documented. Nursing Personnel in-serviced on 8-24-06 and 9-5-06 regarding SWB and survey deficiencies. It will be monitored by the CNO and utilized as a monthly QI indictor. 9/1/2006	

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C 386	485.645(d)(5) SOCIAL SERVICES (483.15(g)) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. A facility with more than 120 beds must employ a qualified social worker on a full-time basis. A qualified social worker is an individual with a bachelor's degree in social work or a bachelor's degree in a human services field including but not limited to sociology, special education, rehabilitation counseling, and psychology; and one year of supervised social work experience in a health care setting working directly with individuals. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the CAH failed to ensure 2 of 2 Swing-bed patients (#26 and 27) were assessed for psychosocial needs. This created the potential that Swing-bed patients would not be provided with medically-related social services, including assistance with advance directives and discharge planning. The findings include: 1. Swing-bed patient records were reviewed on 8/22/06 and the following issues were identified: * Patient #26, an 87 year old male, was admitted to Swing-bed status on 2/17/06. His diagnoses included weakness and debility due to congestive heart failure, chronic renal insufficiency, coronary artery disease and atrial fibrillation. The patient's record did not contain a psychosocial assessment.	C 386	C386 SWB- Social Services. It is the responsibility of the floor nurse/ designee to make sure a psycho-social assessment is done and documented. All SWB patients required discharge planning. Nursing Personnel in-serviced on 9-5-06. This will be monitored by the CNO. See attached check list of Swing Bed actions. 9/15/06	

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C 386	Continued From page 9 The record contained a consent for treatment, which was signed by the patient's spouse on 2/17/06. The section of the form that identified whether or not the patient had a Living Will or Durable Power of Attorney for Health Care, had not been completed. The top half of the patient's "DISCHARGE PLANNING SCREEN", which was signed by an RN on 2/17/06, did not identify if the patient met any of the listed criteria, when, in fact, the patient met two or three of them, including, but not limited to, "Over age 75" and "Chronic or terminal illness". Documentation indicated the patient "May Need Discharge Planning", but no documentation was found to indicate the patients discharge needs had been assessed or that a plan had been developed. The patient was discharged to his home on 3/3/06 with hospice services. No documentation was found to explain how arrangements were made for the patient's care after discharge. * Patient #27, a 75 year old female, was admitted to Swing-bed status on 6/17/06. Her diagnoses included pneumonia, urinary tract infection and multiple sclerosis. The patient's record did not contain a psychosocial assessment. The record contained a consent for treatment, which was signed by the patient on 6/17/06. The section of the form that identified whether or not the patient had a Living Will or Durable Power of Attorney for Health Care, indicated the patient had both. However, no documentation was found on the patient's record to show that staff had inquired about, or otherwise determined, what the	C 386	C386 SWB- Social Services. (Continued) It is the responsibility of the floor nurse/ designee to make sure a psycho-social assessment is done and documented. All SWB patients required discharge planning. Nursing Personnel inserviced on 9-5-06. .This will be monitored by the CNO utilizing a QI tool and daily rounds. See attached Checklist. 9/10/06	

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C 386	Continued From page 10 patient's wishes for emergency treatment were. The top half of the patient's "DISCHARGE PLANNING SCREEN", which was signed by an RN on 6/17/06, did not identify if the patient met any of the listed criteria, when, in fact, the patient met two or three of them, including, but not limited to, "Over age 75" and "Chronic or terminal illness". Documentation indicated the patient "May Need Discharge Planning", but no documentation was found to indicate the patients discharge needs had been assessed or that a plan had been developed. The patient was discharged on 6/19/06 to to a Long Term Care facility for additional rehabilitation. No documentation was found to explain how arrangements were made for the patient's care after discharge. 2. The patients' records were reviewed with the CNO on 8/22/06 at 11:15 AM. She confirmed the lack of psychosocial assessments, advance directive determinations, and incomplete discharge planning documentation.	C 386	C386 SWB- Social Services. (Continued) It is the responsibility of the floor nurse/ designee to make sure a psycho-social assessment is done and documented. All SWB patients required discharge planning. Nursing Personnel inserviced on 9-5-06. .This will be monitored by the CNO utilizing a QI tool and daily rounds. See attached Checklist. 9/1/06	
C 400	485.645(d)(9) NUTRITION (483.25(i)(1)) Based on a resident's comprehensive assessment, the facility must ensure that a resident maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the CAH failed to ensure 2 of 2	C 400	C400 SWB- Nutritional Assessment. It is the responsibility of the floor nurse/ designee to make sure that the dietary services has been notified that SWB patient needs a nutritional assessment.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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	131307	A. BUILDING _____ B. WING _____	08/22/2006

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C 400	Continued From page 11 Swing-bed patients (#26 and 27) were assessed for nutritional needs. This created the potential that Swing-bed patients would maintain acceptable parameters of nutritional status. The findings include: 1. Swing-bed patient records were reviewed on 8/22/06 and the following issues were identified: * Patient #26, an 87 year old male, was admitted to Swing-bed status on 2/17/06. His diagnoses included weakness and debility due to congestive heart failure, chronic renal insufficiency, coronary artery disease and atrial fibrillation. The patient was discharged to his home on 3/3/06 with hospice services. No documentation was found to indicate the patient had received a nutritional assessment. * Patient #27, a 75 year old female, was admitted to Swing-bed status on 6/17/06. Her diagnoses included pneumonia, urinary tract infection and multiple sclerosis. The patient was discharged on 6/19/06 to to a Long Term Care facility for additional rehabilitation. The patient's record contained an evaluation by a speech/language pathologist related to swallowing problems and thickened liquids were ordered. However, no documentation was found to indicate a nutritional assessment had been completed. 2. The patients' records were reviewed with the CNO on 8/22/06 at 11:15 AM. She confirmed the lack of nutritional assessments. 3. The Dietary Supervisor was interviewed on 8/22/06 at 2:45 PM. She stated there was not a specific policy/procedure for initiating a referral to	C 400	C400 SWB- Nutritional Assessment (Continued) The Dietary Supervisor in conjunction with the Charge Nurse, is responsible to make sure that all SWB patients have a nutritional assessment performed and documented. In-service with Dietary Supervisor, Registered Dietician and CNO 8-23-06. See revised P&P D-2. Nursing Personnel In-serviced on 9-5-06. This will be monitored by the CNO. 9/19/06	

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C 400	Continued From page 12 the RD. She stated if nursing put in a request, it would be done. During the same interview, the CNO stated there were no specific guidelines for when the RD would be consulted. The RD contract stated the RD was to complete a nutritional assessment in conjunction with the food service supervisor. In addition, the contract stated the RD was to visit the facility every other month and submit a report on all phases of dietary services, policies and procedures, assessments of food service and all special diets ordered .... According to the Dietary Supervisor's interview on 8/22/06 at 2:45 PM, this had not occurred.	C 400	G400 SWB- Nutritional Assessment (Continued) It is the responsibility of the floor nurse/ designee to make sure that the dietary services has been notified that SWB patient needs a nutritional assessment. The Dietary Supervisor in conjunction with the Charge nurse, is responsible to make sure that all SWB patients have a nutritional assessment performed and documented. In-service with Dietary Supervisor, Registered Dietician and CNO 8-23-06. See revised P&P D-2. Nursing Personnel in-serviced on 9-5-06. This will be monitored by the CNO. 9/18/2006	

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B 000	Initial Comments The following deficiencies were cited during the State licensure survey of your Critical Access Hospital. The surveyors conducting the State licensure survey were: Penny Salow, R.N., H.F.S., Team Leader Gary Guiles, R.N., H.F.S. Deb Dore', R.N., H.F.S.	B 000		
BB223	16.03.14.330.03 Scope of Services 03. Scope of Services. (10-14-88) a. The scope of pharmaceutical service shall be consistent with the needs of the patients and include a program for the control and accountability of drug products throughout the hospital. A pharmacy and therapeutics committee or its equivalent composed of members of the medical staff, the director of pharmaceutical services, the director of nursing services, hospital administration and other health disciplines as necessary, shall develop written policies and procedures for drug selection, preparation, dispensing, distribution, administration, control, and safe and effective use. Refer to Subsections 250.03 and 250.04. (12-31-91) This Rule is not met as evidenced by: Based on staff interview and review of medical staff meeting minutes and hospital policies, it was determined the hospital failed to maintain a pharmacy and therapeutics committee which included the director of pharmaceutical services. The findings include: A policy defining a pharmacy and therapeutics committee was not found during policy review. The CNO stated, during an interview on 8/21/06	BB223	BB223 Pharmacy. Pharmacist will attend P&T meetings/ Medical Staff meetings at least quarterly. The Med Staff Policies will be revised to include a Pharmacy and Therapeutics Committee. Inserviced pharmacist 8-23-06. This will be monitored by the CNO, Medical Staff Coordinator and Administrator. 9/10/06	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: CEO — (X6) DATE: 9/12/2006

STATE FORM 6899 8IIL11 If continuation sheet 1 of 6

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BB223	Continued From page 1 at 3 PM, that there was not a specific pharmaceutical committee, but it was included in the monthly medical staff meeting. The pharmacist was also interviewed on 8/21/06 at 3 PM. He stated he thought he had been to a couple of staff meetings, but was not sure. At the same time the CNO stated that she attended the meetings and attempted to pass on the information from the meetings to the pharmacist. Medical staff meeting minutes documented that meetings were held in December 2005, and February, March, April, May, and June 2006. The pharmacist was not documented as attending any of the meetings.	BB223	BB223 Pharmacy (Continued) Pharmacist will attend P&T meetings/ Medical Staff meetings at least quarterly. The Med Staff Policies will be revised to include a Pharmacy and Therapeutics Committee. Inserviced pharmacist 8-23-06. This will be monitored by the CNO Medical Staff Coordinator, and Administrator. 9/14/06	
BB224	16.03.14.330.04 Policies and Procedures 04. Policies and Procedures. Written policies and procedures shall be developed by the pharmacy and therapeutics committee or its equivalent to govern the pharmaceutical services provided by the hospital. (10-14-88) a. Policies and procedures shall be reviewed revised and amended as necessary, and dated to indicate= the time of last review. (10-14-88) b. Written policies and procedures that are essential for patient safety, and for the control and accountability of drugs, shall be in accordance with acceptable professional practices and applicable federal, state and local laws. (10-14-88) c. Policies and procedures shall include, but are not limited to the following: (10-14-88) i. There shall be a drug recall procedure that can be readily implemented; and (10-14-88)	BB224		

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BB224	Continued From page 2 ii. All medications not specifically prescribed as to time or number of doses shall be controlled by automatic stop orders or other methods; and (10-14-88) iii. Drugs shall be dispensed and administered only upon written or verbal order of a member of the medical staff authorized to prescribe. Verbal orders for drugs shall be given only to those health care practitioners empowered to accept orders under Idaho law and written hospital policies and procedures. Verbal or telephone orders shall be signed by the prescriber within twenty-four (24) hours. The person accepting the verbal or telephone orders shall meet the procedures set forth in Subsection 250.10; and (12-31-91) iv. If patients bring their own drugs into the hospital, these drugs shall not be administered unless they are identified by the pharmacist and a physician's order is written to administer these specific drugs. If the drug(s) that the patient brought to the hospital is (are) not to be used while he is hospitalized, it (they) shall be packaged, sealed, stored, and returned to the patient at the time of discharge; and (10-14-88) v. Self-administration of medications by patients shall not be permitted unless specifically ordered by the physician; and (10-14-88) vi. Investigational drugs shall be used only under the supervision of the principal investigator and after approval for use by the pharmacy and therapeutics committee; and (10-14-88) vii. Acts of drug compounding, packaging, labeling, and dispensing, shall be restricted to the pharmacist or to his designee under supervision;	BB224		

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BB224	Continued From page 3 and (10-14-88) viii. The labeling of drugs and biologicals shall be based on currently accepted professional principles, applicable federal, state, and local laws, and include the appropriate accessory and cautionary instructions, as well as the expiration date when applicable. Only the pharmacist or authorized pharmacy personnel under the supervision of the pharmacist shall make labeling changes; and (10-14-88) ix. Discontinued drugs, outdated drugs, or containers with worn, illegible, or missing labels shall be returned to the pharmacy for proper disposition; and (10-14-88) x. Only approved drugs and biologicals shall be used. (See definition.) A list or formulary of approved drugs shall be maintained in the hospital. (10-14-88) This Rule is not met as evidenced by: Based on staff interview and policy review, it was determined the hospital failed to ensure that the pharmacist identified medications brought into the hospital by patients. The findings include: The pharmacist was interviewed on 8/21/06 at 3 PM. He stated that when patients brought in their own medications to be administered in the hospital, the nursing staff identified the medications. Two charge nurses present during the interview acknowledged that nursing staff were the individuals responsible for identifying the medications. The pharmacy policy and procedure for "Patient's Own Medication", dated 5/2004, documented that nursing staff was responsible for identifying patient medications. Medications were not identified by the pharmacist prior to	BB224	BB224 Pharmacy. Patients own medication policies have been reviewed and updated. Only a pharmacist can approve that the patient's own medications are correct per MD orders. This P&P- Patients Own medication was revised 8-23-06. Pharmacist inserviced 8-23-06. Nursing Personnel inserviced 9-5-06. This will be monitored by the CNO. 9/6/06	

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BB224	Continued From page 4 administration.	BB224		
BB226	16.03.14.330.06 Safe Handling of Drugs 06. Safe Handling of Drugs. In addition to the rules listed below, written policies and procedures which govern the safe dispensing and administration of drugs shall be developed by the pharmacy and therapeutics committee with the cooperation and the approval of the medical staff. (10-14-88) a. The pharmacist shall review the prescriber's original order or a direct copy thereof; and (10-14-88) b. The pharmacist shall develop a procedure for the safe mixture of parenteral products; and (10-14-88) c. All medications shall be administered by trained personnel in accordance with accepted professional practices and any laws and regulations governing such acts; and (10-14-88) d. Each dose of medication administered shall be properly recorded as soon as administered in the patient's medication record which is a separate and distinct part of the patient's medical record; and (10-14-88) e. Drug reactions and medication errors shall be reported to the attending physician and pharmacist in accordance with hospital policy. (10-14-88) This Rule is not met as evidenced by: Based on staff interview it was determined the hospital failed to ensure the pharmacist reviewed physician's original orders or a direct copy there	BB226	BB226 Pharmacy Safe Handling of Drugs. P&P A-6 Pharmacist Review of Physician's Original Orders- reviewed & revised. Pharmacist inservice 8-23-06. Nursing Personnel inserviced 9-5-06. This will be monitored by CNO. 9/10/06	

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BB226	Continued From page 5 of. The findings include: The pharmacist was interviewed on 8/21/06 at 3 PM. He stated that he reviewed physician orders by checking the patient's medication administration record. He stated he did not see the original order or a direct copy of the order.	BB226	BB226 Pharmacy Safe Handling of Drugs P&P A-6 Pharmacist Review of Physician's Original Orders- reviewed & revised. Pharmacist inservice 8-23-06. Nursing Personnel inserviced 9-5-06. This will be monitored by CNO. 9/1/06	